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| AETNA BETTER HEALTH®<br>Coverage Policy/Guideline                                                                                                                                                                                                                                                                                                                                                                                              |                          |
| Name: Iqirvo                                                                                                                                                                                                                                                                                                                                                                                                                                   | Page: 1 of 2             |
| Effective Date: 6/6/2025                                                                                                                                                                                                                                                                                                                                                                                                                       | Last Review Date: 4/2025 |
| Applies to: <div> <input checked="" type="checkbox"/> Illinois <input type="checkbox"/> Florida <input checked="" type="checkbox"/> Florida Kids </div> <div> <input checked="" type="checkbox"/> New Jersey <input checked="" type="checkbox"/> Maryland <input type="checkbox"/> Michigan </div> <div> <input checked="" type="checkbox"/> Pennsylvania Kids <input type="checkbox"/> Virginia <input type="checkbox"/> Kentucky PRMD </div> |                          |

**Intent:**

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Iqirvo under the patient’s prescription drug benefit.

**Description:**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Iqirvo is indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA.

This indication is approved under accelerated approval based on a reduction in alkaline phosphatase (ALP). Improvement in survival or prevention of liver decompensation events have not been demonstrated. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

*Limitations of use: Use of Iqirvo is not recommended in patients who have or develop decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy).*

**Applicable Drug List:**

Iqirvo

**Policy/Guideline:**

**Documentation:**

Submission of the following information is necessary to initiate the prior authorization review:

- A. For initial requests: Pretreatment serum alkaline phosphatase (ALP) level
- B. For continuation of therapy: Current serum alkaline phosphatase (ALP) and/or current total bilirubin level

**Exclusions:**

Coverage will not be provided for members who have or develop decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy).

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| AETNA BETTER HEALTH®<br>Coverage Policy/Guideline                                                                                                                                                                                                                                                                                                                                                                                              |                          |
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**Prescriber Specialty:**

This medication must be prescribed by or in consultation with a hepatologist or gastroenterologist.

**Criteria for Initial Approval:**

**Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis)**

Authorization of 12 months may be granted for treatment of PBC in adult members when all of the following criteria are met:

- A. Diagnosis of PBC is confirmed by at least two of the following criteria:
  - 1. Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration.
  - 2. Presence of antimitochondrial antibodies (AMA) (titer >1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies (ANA) (e.g., anti-gp210, anti-sp100).
  - 3. Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts).
- B. Member has an elevated serum ALP level prior to initiation of therapy with the requested drug.
- C. Member meets either of the following criteria:
  - 1. Member has had an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the member will continue concomitant therapy with UDCA/ursodiol.
  - 2. Member has an intolerance to UDCA/ursodiol.

**Continuation of Therapy:**

Authorization of 12 months may be granted for members who have achieved or maintained a clinical benefit from Iqirvo therapy (i.e., at least a 15% reduction in ALP level, ALP level less than 1.67 times upper limit of normal [ULN], total bilirubin less than or equal to ULN).

**Approval Duration and Quantity Restrictions:**

**Approval:** 12 months

**Quantity limit:** 30 tablets per 30 days

**References:**

- 1. Iqirvo [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; June 2024.
- 2. Lindor KD, Bowlus CL, Boyer J, et al. Primary biliary cholangitis: 2018 Practice guidance from the American Association for the study of liver diseases. *Hepatology*. 2019;69(1):394-419.
- 3. European Association for the Study of the Liver. EASL clinical practice guidelines: The diagnosis and management of patients with primary biliary cholangitis. *J Hepatol*. 2017;67(1):145-172.